MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 24 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 59 Bowery St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): 59 Bowery St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Montgomery (Last) Alexander

4. DATE OF DEATH: (Month) Feb. (Day) 6 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Jan.16-1895

9. AGE last birthday: 55 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: Delivering soft drinks

11. BIRTHPLACE (State or foreign country): Elk Garden W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Alexander

14. MOTHER'S MAIDEN NAME: Katherine Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.1

16. SOCIAL SECURITY NO.: 212-12-8841

17. INFORMANT: (wife) Mrs.J.M.Alexander

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under ying cause last	(b)	Coronary sclerosis	?
	(c)		

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. Feb.6-1950

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF: 2-8-1950
NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
LOCATION (City, town, or county) (State): Alexandria Va.

DATE REC'D BY LOCAL REG. 2-7-50
REGISTRAR'S SIGNATURE: Mrs. Stanley N. Roe

24. FUNERAL DIRECTOR ADDRESS: Jacob Hafer Frostburg, Md.

42043

RECEIVED
FEB 9 1950
BUREAU V. S.

Within corporate limits

01101

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS En route to Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Rural~~ Cumberland, rural
STREET ADDRESS (If rural give location) R.F.D.#3 Bowmans Addition

3. NAME OF DECEASED (Type or Print) (First) Jacob (Middle) H. (Last) Ault
4. DATE OF DEATH (Month) Feb. (Day) 15 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Apr.26-1885
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman
10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry
11. BIRTHPLACE (State or foreign country) Harpers Ferry W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Ault
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-1273
17. INFORMANT James Ault (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion due to	about 10 minutes
940	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
		(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Feb. 16-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Feb 18 '50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem
LOCATION (City, town, or county) Cumberland (State) Md
DATE REC'D BY LOCAL REG. Feb. 17, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc
ADDRESS Cumbd Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

988 47

RECEIVED
FEB 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01102

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
HOSPITAL OR INSTITUTION OR STREET ADDRESS - - - -	STREET ADDRESS (If rural, give location) - - - -

3. NAME OF DECEASED (Type or Print)	(First) MARY	(Middle) ELIZABETH	(Last) BARR	4. DATE OF DEATH	(Month) February (Day) 20 (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow	8. DATE OF BIRTH Dec 27, 1873	9. AGE last birthday 76 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - -	16. SOCIAL SECURITY No. None	17. INFORMANT Mrs. Osborne Clark			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
334 Immediate cause	(a) Hemiplegia	2 yrs
83d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Schrosis	2 yr.
	(c) Hypertension	2 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1950, to Feb 20, 1950, that I last saw the deceased alive on 2-20, 1950, and that death occurred at 3:00 P m., from the causes and on the date stated above.

SIGNATURE J Norman Reeves (Degree or title) M D ADDRESS Westernport, Md DATE SIGNED 2/21/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb 23, 1950	NAME OF CEMETERY OR CREMATORY McNeely Cemetery	LOCATION (City, town, or county) (State) Hambleton, West Virginia
DATE REC'D BY LOCAL REG. Feb. 23/50	REGISTRAR'S SIGNATURE [illegible] M D	24. FUNERAL DIRECTOR E. S. Boal, Westernport, Maryland	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 27 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01103

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 78 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Windsor Hotel Balto, St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): William Thomas Beane
4. DATE OF DEATH (Month) (Day) (Year): Feb. 16 1950
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: March 27 1871
9. AGE last birthday: 78 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Nat. Gas Co
11. BIRTHPLACE (State or foreign country): Allegany Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm T Beane
14. MOTHER'S MAIDEN NAME: Mary Brogan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Rev. Raymond A Beane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cordiac Failure — 1 month

Antecedent cause(s) (b) Coronary Heart Disease — 3 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Generalized arteriosclerosis — ?

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Feb., 1950, to 16 Feb., 1950, that I last saw the deceased alive on 16 Feb., 1950, and that death occurred at 11 50 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Alfred Vn Orme — ADDRESS: Cumberland, Md. — DATE SIGNED: 18 Feb 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2/20/50 — NAME OF CEMETERY OR CREMATORY: Calvery Cem. — LOCATION (City, town, or county) (State): Pittsburgh Pa.

DATE REC'D BY LOCAL REG.: Feb. 18, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

L. Bunge

26677

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

Ask Dr Van Ormer

RECEIVED
FEB 21 1950
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

61164

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 307 Footer Place

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 307 Footer Place

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Andrew (Last) Blubaugh

4. DATE OF DEATH (Month) Feb. (Day) 17, (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH July 24, 1864

9. AGE last birthday 85 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Vale Summit, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Andrew Blubaugh

14. MOTHER'S MAIDEN NAME Sarah Winters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs. Dayton Twigg Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) chronic myocarditis	18 mos
422.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 30, 1950, to Feb. 17, 1950, that I last saw the deceased alive on Feb. 16, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Alex J. Furrey M.D. ADDRESS Cumberland DATE SIGNED 2/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 2-19-1950

NAME OF CEMETERY OR CREMATORY Pleasant Grove

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Feb. 18, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

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RECEIVED
FEB 21 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

61195

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 554 N. Mechanic Street

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Brown
4. DATE OF DEATH: (Month) Feby (Day) 25 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	May 8, 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House	House	Franklin, Maryland	US

13. FATHER'S NAME: Arthur Stuart
14. MOTHER'S MAIDEN NAME: Elizabeth Grey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No	None	Burke Brown, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma head of pancreas — 4 Mo

157 Antecedent cause(s)

46g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June, 1949, to Feb. 25, 1950, that I last saw the deceased alive on Feb 25, 1950, and that death occurred at 10 15 p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Feb. 27, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 28, 1950	St. Patricks Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28 1950	Hunter R. Frank, M.D.	William H. Kight,	Cumberland, Md.

RECEIVED
MAR 6 1950
BUREAU V. S.

H. Jones

Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01106 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Westernport COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 1½	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 Hammond, Street	STREET ADDRESS (If rural, give location) 413 Hammond, Street

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Joseph Francis Carney

4. DATE OF DEATH (Month) (Day) (Year): Feb. 16, 1950 19

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: Jan. 28, 1874 | 9. AGE last birthday: 76 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner | 10b. KIND OF BUSINESS OR INDUSTRY: Coal Miner | 11. BIRTHPLACE (State or foreign country): Beryle W.Va. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Stephen Carney | 14. MOTHER'S MAIDEN NAME: Sara A. Mc Kenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. None | 17. INFORMANT AND ADDRESS: Mrs. Maurice Cummings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic	5 Years
Antecedent cause(s) 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): None | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 21, 1950, to Feb 16, 1950, that I last saw the deceased alive on Feb 16, 1950, and that death occurred at 7:00 P.m., from the causes and on the date stated above.

SIGNATURE: Paul R Wilson (Degree or title) MD. ADDRESS: Piedmont, W. Va DATE SIGNED: Feb 18, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Feb. 20, 1950 | NAME OF CEMETERY OR CREMATORY: St. Peters | LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: Feb 20/50 | REGISTRAR'S SIGNATURE: [signature] MD | 24. FUNERAL DIRECTOR: E. S. Boal ADDRESS: Westerport, Md.

454 V2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
FEB 21 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01107

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sunnyside
LENGTH OF STAY (in this place): 10yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Mt. Savage

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sunnyside
STREET ADDRESS (If rural, give location): Mt. Savage

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) Ellen (Last) Chambers

4. DATE OF DEATH: (Month) 2 (Day) 10 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 5-29-1869

9. AGE last birthday: 80 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Midlothian, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Tighe

14. MOTHER'S MAIDEN NAME: Magadline Haller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Thomas Carter, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: Instant.

331 Antecedent cause(s)

830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — Several Years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anaemia -

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1, 1950, to 2-10, 1950; that I last saw the deceased alive on 2-10, 1950, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William E. Morley M.D. Mt. Savage, Md. 2-11-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 2-13-50 | NAME OF CEMETERY OR CREMATORY: St. Michaels | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 2-13-50 | REGISTRAR'S SIGNATURE: Veronica McDermott | 24. FUNERAL DIRECTOR: Jacob Hafer | ADDRESS: Frostburg Md

RECEIVED
FEB 15 1950
BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

81198

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 400 Virginia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 400 Virginia Ave.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) George (Last) Conway

4. DATE OF DEATH: (Month) Feb (Day) 22 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 29 1875

9. AGE last birthday: 75 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Prop.

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Port Jervis, N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Michael Conway

14. MOTHER'S MAIDEN NAME: Ellen Gary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Leo Henry Conway Cumb'd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Sudden

151 Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Stomach — 3 yrs

460 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Feb. 23, 1950, that I last saw the deceased alive on Feb. 23, 1950, and that death occurred at 940 P. m., from the causes and on the date stated above.

SIGNATURE: Chas R. Lewis — (Degree or title) M.D. — ADDRESS: Cumberland — DATE SIGNED: 2/24/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Feb 25 1950 — NAME OF CEMETERY OR CREMATORY: St Peter + Pauls Cem'y — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Feb. 25, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumb'd Md

15671

RECEIVED
MAR 1 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11109

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STATE MARYLAND; LENGTH OF STAY (in this place) 6 yrs 2 mos; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY Allegany Md; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 215 Decatur St.

3. NAME OF DECEASED (Type or Print): (First) SISTER (Middle) MARGUERITE (Last) CROTTY

4. DATE OF DEATH: (Month) Feb (Day) 12 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: Sept 3 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hospital administrator

10b. KIND OF BUSINESS OR INDUSTRY: Sister of Charity

11. BIRTHPLACE (State or foreign country): Ottawa, Illinois

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas Crotty

14. MOTHER'S MAIDEN NAME: Ellen Boyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Sister Angela, Allegany Hospital, Cbld.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) arteriosclerotic Heart Disease — Interval Between Onset and Death: ?

420.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) "

(c) Generalized arteriosclerosis — 3

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. dermatitis, exfoliata, chronic, gen-

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 July, 1949, to Feb 12, 1950, that I last saw the deceased alive on Feb. 11, 1950, and that death occurred at 6.23 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Alfred Van Orman — ADDRESS: 531 Louisiana Ave, Cumb, Md — DATE SIGNED: Feb 13, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Feb 14 '50 — NAME OF CEMETERY OR CREMATORY: St Patricks Cem — LOCATION (City, town, or county): Cumberland (State): Md

DATE REC'D BY LOCAL REG.: Feb. 14, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D. — 24. FUNERAL DIRECTOR: Loma Stein Inc, Cumberland — ADDRESS:

15697

RECEIVED
FEB 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11110

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 1 yr.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart, Md.; STREET ADDRESS (If rural, give location) 220

3. NAME OF DECEASED (Type or Print): (First) Reginald (Middle) Palmer (Last) Crane

4. DATE OF DEATH: (Month) 2 (Day) 18 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 7-18-1887

9. AGE last birthday: 62 yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick D. Crane

14. MOTHER'S MAIDEN NAME: Mary Ann Pengelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Fred Crane Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151 Immediate cause (a) Carcinoma of stomach. — Interval Between Onset and Death: 1½ yrs.

Antecedent cause(s)

46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malnutrition.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15, 1949, to 2-18, 1950, that I last saw the deceased alive on 2-18, 1950, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. C. Dickl, M.D. | ADDRESS Frostburg, Md. | DATE SIGNED 2/20/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 2-21-1950 | NAME OF CEMETERY OR CREMATORY Eckhart Cem. | LOCATION (City, town, or county) (State) Eckhart, Md.

DATE REC'D BY LOCAL REG. 2-20-50 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR Jacob Hofer | ADDRESS Frostburg, Md.

VS. A15

4544

RECEIVED
FEB 24 1950
BUREAU V. S.

McLane

01111

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): 2 wks.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barton
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) JOHN	(Middle) WILLIAM	(Last) DAWSON	4. DATE OF DEATH	(Month) Feb. (Day) 7, (Year) 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: 8-15-1873	9. AGE last birthday: 76 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner	10b. KIND OF BUSINESS OR INDUSTRY: Coal mines	11. BIRTHPLACE (State or foreign country): Barton, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Arnold Dawson	14. MOTHER'S MAIDEN NAME: unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: 185-05-4141	17. INFORMANT AND ADDRESS: Mrs. Thelma Truly, Frostburg, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertension ??

443 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr Myocarditis ??

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 24, 1950, to Feb 7, 1950, that I last saw the deceased alive on Feb 7, 1950, and that death occurred at 11 20 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W O McLane MD		Frostburg Md	2-8-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 2-9-50	NAME OF CEMETERY OR CREMATORY: Allegany Cemetery	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 2-9-50	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

454V2

RECEIVED
FEB 13 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01112

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; STREET ADDRESS (If rural, give location) Oregon Farms Rt. #4

3. NAME OF DECEASED (Type or Print): (First) Genetta (Middle) Bell (Last) Dolly

4. DATE OF DEATH: (Month) Feb. (Day) 18 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 6 1869

9. AGE last birthday: 81 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Mouth of Seneca, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sampson Sites

14. MOTHER'S MAIDEN NAME: Eve Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Ethel Dolly, Oregon Farms

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 6 days

332 Antecedent cause(s)

831 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/5/50, 19..., to 2/14/50, 19..., that I last saw the deceased alive on 2/18/50, 19..., and that death occurred at 5:25 P. m., from the causes and on the date stated above.

SIGNATURE R. R. Williams (Degree or title) MD ADDRESS Cumberland, Md DATE SIGNED 2/20/50

23. INITIAL CREMATION (Specify): Burial — DATE 2/21/50 — NAME OF CEMETERY OR CREMATORY Peterson Family Cem. — LOCATION (City, town, or county) Peterson, — (State) W. Va.

DATE REC'D BY LOCAL REG. Feb. 20, 1950 — REGISTRAR'S SIGNATURE Walter L. Bantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland Md

RECEIVED
MAR 1 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1113 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 321 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) -- -- (Last) Dougherty
4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1950
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated
8. DATE OF BIRTH: ~~October~~ 1873
9. AGE last birthday: abt. 76 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Mrs. Miller, Sylvan Retreat

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	1 Mo
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1948, to Feb. 22, 1950, that I last saw the deceased alive on Feb. 21, 1950, and that death occurred at 1:15 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Arthur F. Jones M.D. | Cumberland, Md. | Feb. 23 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Feb. 24, 1950 | NAME OF CEMETERY OR CREMATORY: St. Peters and Pauls | LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Feb. 24, 1950 | REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D. | 24. FUNERAL DIRECTOR: John J. Lopez | ADDRESS: Cumberland, "

RECEIVED
MAR 1 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01114

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland Rural
STREET ADDRESS (If rural, give location) Locust Grove, R.F.D. #6

3. NAME OF DECEASED (Type or Print): (First) William (Middle) ~~Drewnoski~~ (Last) Drewnoski
4. DATE OF DEATH: (Month) 2 (Day) 12 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: 5/7/65
9. AGE last birthday: 84 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: cement worker
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael ~~Drewnoski~~ Drewnoski
14. MOTHER'S MAIDEN NAME: Louisa Hohenstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Himself

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	5 wks
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	12 wks
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 15, 1949, to Feb. 12, 1950, that I last saw the deceased alive on Feb. 11, 1950, and that death occurred at 9:55 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Feb. 14, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/15/50	Greenmount Cem.	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 15, 1950	Hunter R. Canty, M.D.	John J. Hafer	Cumberland Md.

496.23

RECEIVED
FEB 21 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

61115

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 2.1/2 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) William (Last) Elliott

4. DATE OF DEATH: (Month) Feb. (Day) 13 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Feb. 19-1924

9. AGE last birthday: 25 yrs. — If under 1 year: Months — If under 24 hrs.: Days / Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Repairing autos.

11. BIRTHPLACE (State or foreign country): East Pittsburg Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert E Elliott

14. MOTHER'S MAIDEN NAME: Estella Duckworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.2

16. SOCIAL SECURITY NO.: 218-16-3721

17. INFORMANT: Lawerance Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.6 **Immediate cause** (a) Cerebral hemorrhage due to a — Interval between onset and death: ?

157f **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) congenital aneurysm.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN): (COUNTY): (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V.Deming M.D. H V Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Feb.13-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2-15-1950 — NAME OF CEMETERY OR CREMATORY: Mt. Herman — LOCATION (City, town, or county) (State): Near Cumberland, Md

DATE REC'D BY LOCAL REG.: Feb. 14, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz. M.D

24. FUNERAL DIRECTOR — ADDRESS: Charles L. George Cumberland, Md.

33284

RECEIVED
FEB 21 1950
BUREAU V. S.

Within corporate limits

DR. DYER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01116

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2-DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 50 ELDER ST.

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) D (Last) ELLIS

4. DATE OF DEATH: (Month) FEB. (Day) 17 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: JUNE 1, 1870

9. AGE last birthday: 79 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conman -

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R. R. Co.

11. BIRTHPLACE (State or foreign country): MARYLAND Baltimore

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN E ELLIS

14. MOTHER'S MAIDEN NAME: THEDOCIA TURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-09-9696

17. INFORMANT AND ADDRESS: Memorial Hosp., Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	16 hrs.
Antecedent cause(s)		
443		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive heart disease	6 mos.
932	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-15-, 1949, to 2-17-, 1950, that I last saw the deceased alive on 2-17-, 1950, and that death occurred at 6:25 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John Dyer, M.D. 247 Baltimore Ave, Cumberland 2-17-50

23. BURIAL, CREMATION, REMOVAL (Specify) DATE: Feb 20 1950 NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 17, 1950 REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight Cumberland, Md.

98447

Keyl

RECEIVED
FEB 21 1950
BUREAU V. S.

Within corporate limits

DR. - WEISMAN, evidence for change of age shown on: FILM No. G 124 MAR 15 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1117

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location): 318 AVIRETT AVE.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DEWEY	H.	EVERETT	FEB.	22	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	JUNE 10, 1900	49 50 yrs.	9			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Furniture Store	W. VA	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DAVID EVERETT	MARY PAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
Yes W.W. I	234-12-1568	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart failure (Pulmonary + Peripheral)	1 week
420.0 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic and Hypertensive Heart Disease	2 yrs
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Myocardial Infarction (old) Bilateral amputations of mid Thighs (old)	6 mos 6 mos

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
no	no	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
no	no			

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		no

22. I hereby certify that I attended the deceased from Feb 20, 1950, to Feb 22, 1950, that I last saw the deceased alive on Feb 21, 1950, and that death occurred at 8 55 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Harold G. Weisman MD		122 Bedford St Cumberland Md	2/23/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 24, 1950	Queen's Point Cemetery	Keyser,	W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 24, 1950	Wynter K. Hantz, M.D.	John J. Hafey	Cumberland, Md.

27867

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 1 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01118

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 65 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 116 N Allegany Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 116 N Allegany Street

3. NAME OF DECEASED (Type or Print): (First) Harriett (Middle) Rebecca (Last) Fielding

4. DATE OF DEATH: (Month) Feby (Day) 25 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept 7 1868

9. AGE last birthday: 81 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Pittsburgh Penna

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Josiah Holmes

14. MOTHER'S MAIDEN NAME: Fannie Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: H.W. Fielding, 116 N Allegany St Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic myocarditis — Interval Between Onset and Death: 2 years

422.2 Antecedent cause(s)

930 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 4, 1950, to Feb 25, 1950, that I last saw the deceased alive on Feb 24, 1950, and that death occurred at 3:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): L. W. Trevaskis, M.D. — ADDRESS: Cumberland, Maryland — DATE SIGNED: 2/25/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Feby 28 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Feb. 27, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
MAR 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01119

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart; LENGTH OF STAY (If this place) Lifetime; HOSPITAL OR INSTITUTION OR STREET ADDRESS R-2. #1 Frostburg

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart; STREET ADDRESS (If rural, give location) R-2. #1 Frostburg, Md

3. NAME OF DECEASED (Type or Print): (First) Albert; (Middle) William; (Last) Fabinger

4. DATE OF DEATH: (Month) 2; (Day) 28; (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 7-2-1900

9. AGE last birthday: 49 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Eckhart, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Fabinger

14. MOTHER'S MAIDEN NAME: Louise Daugherty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Herman Fabinger, Eckhart, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 15 Hrs.

331

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death hut not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 27, 1950, to Feb 28, 1950, that I last saw the deceased alive on Feb 27, 1950, and that death occurred at 7:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W O McLane MD Frostburg Md 2-28-50

23. BURIAL, CREMATION / REMOVAL (Specify): Burial; DATE: 3-2-1950; NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery; LOCATION (City, town, or county) Eckhart; (State) Md.

DATE REC'D BY LOCAL REG. 3-2-50; REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer; ADDRESS: Frostburg, Md

988-50

RECEIVED
MAR 7 1950
FBI - BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01120

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural give location) Watercliffe Street

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Doyle (Last) Foote

4. DATE OF DEATH: (Month) Feb (Day) 3 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: May 2, 1866

9. AGE last birthday: 83 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Nova Scotia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Doyle

14. MOTHER'S MAIDEN NAME: Annie Frazier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Catherine Freeman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	5 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis - Hypertension	1 yr
	(c) Chronic Myocarditis	1 yr

422.1 / 50 / 170

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of st breast — 6 mos.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30, 1950, to Feb 3, 1950, that I last saw the deceased alive on 2/3, 1950, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Norman Reece, M.D. ADDRESS Westernport Md DATE SIGNED Feb 4, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Feb 6, 1950

NAME OF CEMETERY OR CREMATORY Oakhill Cemetery

LOCATION (City, town, or county) Lonaconing (State) Md

DATE RECD BY LOCAL REG. 2/6/50

REGISTRAR'S SIGNATURE Jeannette M Boal

24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md

RECEIVED
FEB 24 1950
BUREAU V. R.

Within corporate limits W. F. WILLIAMS

01121

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. | LENGTH OF STAY (in this place) 20 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MICHIGAN — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DETROIT
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) MARIE (Middle) Baitre (Last) GANK
4. DATE OF DEATH: (Month) 2-6-50 (Day) (Year) 19
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: OCT. 2, 1875
9. AGE last birthday: 74 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN B. STEIDING
14. MOTHER'S MAIDEN NAME: ELIZABETH A. BAITRE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinomatosis of

154 Antecedent cause(s)

46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) abdominal viscera ?

(c) Carcinoma of rectum ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-13-50, 19.., to 2-6-50, 19.., that I last saw the deceased alive on 2-6, 19.., and that death occurred at 5:33 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm F. Williams MD. Cumberland 2/7/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Feb. 9, 1950 | NAME OF CEMETERY OR CREMATORY Queen's Point Cem | LOCATION (City, town, or county) (State) Keyser West Virginia

DATE REC'D BY LOCAL REG. Feb. 7, 1950 | REGISTRAR'S SIGNATURE Vernon R. Frantz, M.D. | 24. FUNERAL DIRECTOR E. S. Boal | ADDRESS Westernport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 14 1950
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01122

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 727 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Harry (Last) Grubb
4. DATE OF DEATH: (Month) Feb (Day) 28 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Mar. 27, 1866
9. AGE last birthday: 83 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed
10b. KIND OF BUSINESS OR INDUSTRY: Lumber dealer
11. BIRTHPLACE (State or foreign country): Clearville, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Grubb
14. MOTHER'S MAIDEN NAME: Margaret Dodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Verlinda Grubb, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Thrombosis — 1 week.

332 Antecedent cause(s)

83b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ~~March~~ Feby 27, 1950, to Feby 28, 1950, that I last saw the deceased alive on Feby 28, 1950, and that death occurred at 10:00 A.m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler (Degree or title) M.D. — ADDRESS: 41 Greenett, Cumberland, Md. — DATE SIGNED: March 1, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Mar. 2, 1950 — NAME OF CEMETERY OR CREMATORY: Union Cemetery — LOCATION (City, town, or county): Clearville, (State) Pa

DATE REC'D BY LOCAL REG.: March 2, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md. — ADDRESS:

122-60

RECEIVED
MAR 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01123

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 160 W. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 160 W. Main St.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) GUNTER

4. DATE OF DEATH: (Month) Feb. (Day) 3, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 4-10-1867

9. AGE last birthday: 82 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Conrad Haberlein

14. MOTHER'S MAIDEN NAME: Caroline Eberly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Helen Gunter, Pittsburgh, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 **Immediate cause** (a) Cerebral Hemorrhage — Interval between onset and death: 4 days

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Senility.

(c) Hypertension, arterio-sclerosis.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 1-31, 1950, to 2-3, 1950, that I last saw the deceased alive on 2-3, 1950, and that death occurred at 10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — **ADDRESS** — **DATE SIGNED**

H. C. Diehl, M.D. — Frostburg, Md. — 2-4-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE**: 2-6-50 — **NAME OF CEMETERY OR CREMATORY**: Allegany Cemetery — **LOCATION** (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 2-6-50 — **REGISTRAR'S SIGNATURE**: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR — **ADDRESS**: J. R. Durst, Frostburg, Md.

RECEIVED
FEB 9 1950
BUREAU V. S.

within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01124

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 14 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 428 Virginia Ave.

3. NAME OF DECEASED (Type or Print): (First) Michael (Middle) (Last) Holshey (Holezog)

4. DATE OF DEATH: (Month) Feb. (Day) 22 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: July 4-1872

9. AGE last birthday: 77 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Tinner

10b. KIND OF BUSINESS OR INDUSTRY: Steel Rolling Mill

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? no

13. FATHER'S NAME: Patrick Holshey (Holezog)

14. MOTHER'S MAIDEN NAME: Kathleen ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-15-9215

17. INFORMANT: son) Nicholas Holshey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under lying cause last	(b) Leukemia (myelogenic)	2 yrs.
	(c) arteriosclerosis& cardio-vascular disease	5 yrs.

204.1
Tha

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Feb.22-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Feb. 24, 1950
NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Feb. 23, 1950
REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR: James Scarpelli
ADDRESS: "

49629

RECEIVED
AUG 1 1950
BUREAU V. S.

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

01125

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 415 Furnace St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 415 Furnace St.

3. NAME OF DECEASED (Type or Print): (First) Mortimer (Middle) C. (Last) Isaacs

4. DATE OF DEATH: (Month) Feb. (Day) 21 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Oct. 12-1879

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver & helper

10b. KIND OF BUSINESS OR INDUSTRY: Furniture E.V.Coyle Store

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Isaacs

14. MOTHER'S MAIDEN NAME: Mary Mahaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-9552

17. INFORMANT: wife) Georgia Rexroad Isaacs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Chronic myocarditis	?

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Feb.21-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Feb.23,1950
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 22, 1950
REGISTRAR'S SIGNATURE: Urner R. Krantz, M.D.
24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.
ADDRESS

VS. A15A

420 67

RECEIVED
MAR 1 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01126

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): D.O.A.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 175 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Thomas	Johnson	Feb.	25	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married	March-15-1878	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done durlog most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sweeper(retired)	Celanese Corp.	Martinsburg W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Johnson	Mary Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	214-07-5151	Edith Schellingburg Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary occlusion due to	about 3 min.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Myocardial degeneration	over 2 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Feb. 25-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 28 1950.	Greenmount Cem.	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28, 1950	Winter R. Wantz, M.D.	Louis Stein Inc.	Cumb. Md.

714-16

RECEIVED
MAR 6 1950
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01127

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street,	STREET ADDRESS (If rural, give location) Main Street,

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) R.	(Last) Keller.	4. DATE OF DEATH	(Month) (Day) (Year) February 27, 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Marries	8. DATE OF BIRTH March 1, 1874	9. AGE last birthday 75 yrs.	If under 1 year Months 11 Days 26; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Master Plumber.	10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) Germany.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Don't Know.		14. MOTHER'S MAIDEN NAME Don't Know.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 236-12-1843	17. INFORMANT AND ADDRESS Mrs. John R. Keller.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral thrombosis	4 days
332 Antecedent cause(s)		
83b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Cerebral arteriosclerosis	4 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1945, to Feb 27, 1950, that I last saw the deceased alive on Feb 27, 1950, and that death occurred at 12 30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James H. Wilkerson Jr	MD	Piedmont W. Va	2-28-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3-1-50.	NAME OF CEMETERY OR CREMATORY Philos Cemetery,	LOCATION (City, town, or county) (State) Westernport, Md.
DATE REC'D BY LOCAL REG. Mar. 1/50	REGISTRAR'S SIGNATURE [illegible] MD	24. FUNERAL DIRECTOR W. Harold Fredlock Jr	ADDRESS Piedmont, West Va.

348-16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 3 1950
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01128

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: on walk in front of 342 Mt. Vieu Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 613 Memorial Ave

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Thomas (Last) Kerlin
4. DATE OF DEATH: (Month) Feb (Day) 21 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: March 22-1866
9. AGE last birthday: 83 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Prof.
10b. KIND OF BUSINESS OR INDUSTRY: English Teacher
11. BIRTHPLACE (State or foreign country): New Castle, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: John Lindsley Kerlin
14. MOTHER'S MAIDEN NAME: Nancy Jane Jefferies
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-24-6173
17. INFORMANT: wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	
	(c) also had a chronic myocarditis	several years

420.1
92d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Feb. 21-1950

23. BURIAL, CREMATION REMOVAL (Specify): Cremation
DATE THEREOF: Feb. 25, 1950
NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG.: Feb 23, 1950
REGISTRAR'S SIGNATURE: Winter K. Dantz, M.D.
24. FUNERAL DIRECTOR ADDRESS: John F. Hotter, Cumberland, Md.

V1091

RECEIVED
APR 1 1950
U. S. BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01129

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mercer Hospital 255 Welsh Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 255 Welsh Hill

3. NAME OF DECEASED (Type or Print) (First) Inna (Middle) Franklin (Last) Lancaster

4. DATE OF DEATH (Month) 2 (Day) 7 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 3-1-1872
9. AGE last birthday 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm
10b. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (State or foreign country) Lane's Mt. Md.
12. CITIZEN OF WHAT COUNTRY? N.S.A.

13. FATHER'S NAME Andrew Lancaster
14. MOTHER'S MAIDEN NAME Charlotte Lawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS 255 Welsh Hill Mrs Inna Lancaster, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	5 days
420.0 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic heart + vascular disease	6 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November, 1944, to Feb. 7, 1950, that I last saw the deceased alive on Feb. 7, 1950, and that death occurred at 12:30 pm., from the causes and on the date stated above.

SIGNATURE Hilda Jouel Valtry (Degree or title) M.D. ADDRESS Frostburg, Maryland DATE SIGNED Feb. 8, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-9-1950
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 2-9-50
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
FEB 13 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

(1130)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 26 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) 614 Frederick St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Anna	Estelle	Long	Feb.	27	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	March 21, 1903	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Keyser, West Va.	U.S.A.

13. FATHER'S NAME: Dr. Dorsey B. Shore

14. MOTHER'S MAIDEN NAME: Annie Wike

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO None	214-07-2801	Mr. Herman H. Long - 614 Frederick St.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a)	Uremia	1 month
593 Antecedent cause(s)		
132 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Nephritis	(?)
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/13, 1950, to 2/27, 1950, that I last saw the deceased alive on 2/27, 1950, and that death occurred at 12:55 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George M Jenson	M.D.	128 Union St	Cumberland, Md

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	March 2, 1950	Rose Hill Cemetery	Cumberland,	Md.

DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 2, 1950	Winter K. Lantz, M.D.	John J. Hofer,	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

RECEIVED
MAR 6 1950
BUREAU V. S.

DR, DYER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01131

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 6-DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.VA. — COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WILEY FORD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LLEWELLYN		MacVETTIE	FEB.	16	50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE	SINGLE	FEB 14 1914	36 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator
10b. KIND OF BUSINESS OR INDUSTRY: Kirschell Airplane Factory
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morgan MacVETTIE
14. MOTHER'S MAIDEN NAME: ANNA SHIPLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac decompensation	3 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Rheumatic heart disease	10 yr.
	(c) Uremia	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-14-50, to 2-16-50, that I last saw the deceased alive on 2-16-50, and that death occurred at 4:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
John A Dyer, M.D. 247 Baltimore Cumberland 2-17-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 18, 1950	Rose Hill Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 17, 1950	W. R. Wantz, M.D.	John J. Hafer, Cumberland,	"

-49038

RECEIVED
FEB 21 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11132

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 218 Park Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible] Frostburg
STREET ADDRESS (If rural, give location) [illegible] Jackson St.

3. NAME OF DECEASED (Type or Print): (First) Paul (Middle) Eugene (Last) Matthews

4. DATE OF DEATH: (Month) Feb (Day) 14 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Child

8. DATE OF BIRTH: June 5, 1949

9. AGE last birthday: yrs.

If under 1 year: Months 8 Days 9

If under 24 hrs.: Hours [illegible] Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver Matthews

14. MOTHER'S MAIDEN NAME: Pauline Metheny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT: Mrs Pauline Matthews,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

752 Immediate cause (a) Hydrocephalus, meningocele — Interval between onset and death: 8-9 months

157.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1949, to Feb. 14, 1950 that I last saw the deceased alive on Feb. 13, 1950, and that death occurred at 5:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B. M. Schindler M.D. 41 Greene St. Cumberland, Md. Feb. 14 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Feb 16 1950

NAME OF CEMETERY OR CREMATORY: Laural Hill Cemetery

LOCATION (City, town, or county) (State): Moscow Md

DATE REC'D BY LOCAL REG. 2-15-50

REGISTRAR'S SIGNATURE: G. K. Krantz, M.D.

24. FUNERAL DIRECTOR: M. Eichhorn

ADDRESS: Lonaconing, Md

2-0-6-05-9-25-1-40-X

X VX 99

RECEIVED
FEB 21 1950
BUREAU V. S.

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

(1133

FILM No. G 124 FEB 15 1950

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) Lifetime; HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Yhlf St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 16 Yhlf St

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) (Last) Mayer

4. DATE OF DEATH: (Month) 2 (Day) 7 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Feb. 12 1867

9. AGE last birthday: 82 53 yrs. If under 1 year: Months 11 Days 26 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Mayer

14. MOTHER'S MAIDEN NAME: Elizabeth Dermy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: Mrs Virgil Githeimer 164 Yhlf St. Frostburg Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremic Poisioning — Interval between onset and death: 2 days.

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Metastatic Carcinoma in Kidney — ?

(c) Grade IV Carcinoma cervix — over 1 Year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 48, to 7 Feb, 1950, that I last saw the deceased alive on 7 Feb., 1950, and that death occurred at 230 A m., from the causes and on the date stated above.

SIGNATURE: John B. Davis (Degree or title) MD ADDRESS Frostburg, Md DATE SIGNED 2/7/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 2-9-1950 NAME OF CEMETERY OR CREMATORY Luthern Cemetery LOCATION (City, town, or county) Frostburg (State)

DATE REC'D BY LOCAL REG. 2-7-50 REGISTRAR'S SIGNATURE Mrs Nancy N Roe

24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg Md

RECEIVED
FEB 9 1950
BUREAU V. S.

Within corporate limits DR. SIMONS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01134

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 11
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 410 VIRGINIA AVENUE

3. NAME OF DECEASED (Type or Print): (First) ALFRED (Middle) Q. (Last) MC DONALD

4. DATE OF DEATH: (Month) FEB. (Day) 2, (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: MAY [redacted], 1905

9. AGE last birthday: 44 yrs. — If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Surveyor from Retail

10b. KIND OF BUSINESS OR INDUSTRY: Clemens Corp.

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: VIRGIN A. MC DONALD

14. MOTHER'S MAIDEN NAME: BLANCHE V. PEER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-8903

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Malignant Hypertension & uremia — 6 months

4445 Antecedent cause(s)

102 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 24, 1950, to Feb 2, 1950, that I last saw the deceased alive on Feb 2, 1950, and that death occurred at 7:55PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

George M Simons M.D. 129 Union St Cumb. Md. 2/2/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 2/5/50 — NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park — LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Feb. 4, 1950 — REGISTRAR'S SIGNATURE Walter K. Frantz, M.D. — 24. FUNERAL DIRECTOR James F. Scarpelli — ADDRESS Cumberland Md

382-16

RECEIVED
FEB 7 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01135

Reg. Dist. No. 9

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 90 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 90 Mechanic

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 90 Mechanic St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Sarah Ann McDonald

4. DATE OF DEATH (Month) (Day) (Year): 2 17 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Apr. 15-1865
9. AGE last birthday: 84 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? Nat. A.

13. FATHER'S NAME: Richard McCready
14. MOTHER'S MAIDEN NAME: Ellen Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: John McDonald 101 R. R. St. Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic myocarditis. — 2 years.

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-sclerosis.

(c) Senility.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1948, to 2-17, 1950, that I last saw the deceased alive on 2-17, 1950, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED: H. C. Diehl, M.D. Frostburg, Md. 2/17/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-20-1950 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cem. — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 2-20-50 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe — 24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md

Dr. Diehl

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 24 1950
BUREAU V. S.

Within corporate limits

DR. TOPPER
Evidence for addition
in #18 shown on:

FILM No. G 12 FEB 27 1950

01136

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 66 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 309 SPRINGDALE STREET

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) V (Last) McKINLEY

4. DATE OF DEATH (Month) ~~JAN.~~ Feb (Day) 5 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH JAN 21, 1911
9. AGE last birthday 39 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY B&O RR
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CHARLES W. McKINLEY
14. MOTHER'S MAIDEN NAME MARIE BELLA HAGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY No. 214-05-9714
17. INFORMANT AND ADDRESS MEMORIAL Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
	Immediate cause	(a) Septicemia	6 wks
576	Antecedent cause(s)		
129	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Duodenal ulcer	?
		(c) Generalized Peritonitis (2/28/50 - a.s.)	8 wks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 11, 1950, to Feb 5, 1950, that I last saw the deceased alive on Feb 5, 1950, and that death occurred at 6:50 p.m., from the causes and on the date stated above.

SIGNATURE John A Topper (Degree or title) Md ADDRESS Hyndman Pa DATE SIGNED 2.7.50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2/8/50 February
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland Md (State)

DATE REC'D BY LOCAL REG. Feb. 7, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR James F. Scarfelli ADDRESS Cumberland Md

988-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
FEB 14 1950
BUREAU U. S.

Within corporate limits Dr. Hallinan

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01137

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 511 Washington

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 511 Washington St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Rose Bridget McMullen

4. DATE OF DEATH (Month) (Day) (Year) Feb. 12, 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 1-14-1871
9. AGE last birthday 79 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Frank McNamee
14. MOTHER'S MAIDEN NAME Mary Monahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. M.F. Prendergast Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	
Antecedent cause(s)	(b) Arteriosclerotic Heart Disease	10 Yr.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Unreduced fracture left hip	3 Yrs.

420.0

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December, 1949, to Feb. 12, 1950, that I last saw the deceased alive on Feb. 12, 1950, and that death occurred at 6:20 P m., from the causes and on the date stated above.

SIGNATURE James P. Hallinan (Degree or title) M.D. ADDRESS 200 Decatur St. Cumberland Md. DATE SIGNED 2/14/1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-15-1950
NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Feb. 14, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

RECEIVED
FEB 21 1950
BUREAU U. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01138

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 340 Central Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 340 Central Ave.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Spriggs (Last) Meekins

4. DATE OF DEATH (Month) Feb. (Day) 26 (Year) 1950

5. SEX male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower

8. DATE OF BIRTH Nov.22-1870

9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor & Walter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Piney Grove Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Meekins

14. MOTHER'S MAIDEN NAME Margaret Ann --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis	several
443 x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	years
93d	(c) arteriosclerosis with hypertention	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Feb-27-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF March 2, 1950 NAME OF CEMETERY OR CREMATORY Summer Cem. LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Feb. 28, 1950 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumb. Md.

74083

RECEIVED
MAR 6 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01139

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peoples Hdw. Store 28 South George St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Frostburg
STREET ADDRESS (If rural give location): Star Route

3. NAME OF DECEASED (Type or Print): (First) Cecil R. (Middle) Reese (Last) Michael
4. DATE OF DEATH: (Month) Feb. (Day) 21 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married	Feb. 23-1890	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Rural) Garrett Co. Md.	U.S.A.

13. FATHER'S NAME: Benjamin F. Michael
14. MOTHER'S MAIDEN NAME: Ella Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	--	Earl C. Michael

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) also had a chronic myocarditis	about 2 years

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.		Cumberland Md.	Feb. 21-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/24/50	Mt Zion Meth Cemetery	Garrett County	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 23, 1950	Wintes K. Kantz, M.D.	John J. Hafer	Cumberland Md.

VS. A15A

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RECEIVED
MAR 1 1950
BUREAU V. S.

M

01140

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 31 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 30 Fraft Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 30 Fraft Ave.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) (Last) Morton

4. DATE OF DEATH (Month) 2 (Day) 4 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Oct. 11-1874
9. AGE last birthday 75 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Garage Owner
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Conseming, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Morton
14. MOTHER'S MAIDEN NAME Janet Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Fred Morton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Congestive Heart Failure	1 hr.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocardial Disease	10 yrs
	(c) Hyperthyroid	15 yrs.

252.0
63b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1948, to 4 Feb, 1950, that I last saw the deceased alive on 4 Feb, 1950, and that death occurred at 7 30 A m., from the causes and on the date stated above.

SIGNATURE John B. Davis (Degree or title) M.D. ADDRESS Frostburg, Md DATE SIGNED 2/4/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-6-1950
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 2-6-50
REGISTRAR'S SIGNATURE Mrs. Nancy H Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 9 1950
BUREAU V. S.

Within corporate limits

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01141

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENN. COUNTY SOMERSET
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 12 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FAIRHOPE
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) EMMA	(Middle) R.	(Last) NORRIS	4. DATE OF DEATH	(Month) FEB. (Day) 27 (Year) 1950
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH JAN. 17 1878	9. AGE last birthday 72 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENNA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME BAUER, JOHN		14. MOTHER'S MAIDEN NAME Mary Coughenour			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Arterio-Sclerotic Cardio-Vascular Disease — 15 yrs.

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1940, to 2-27, 1950, that I last saw the deceased alive on 2:26, 1950, and that death occurred at 3:25 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John A Topper	MD	Hyndman Pa	2.27.50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/28/50	Mt Olive Lutheran	Glen Savage	Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28, 1950	Winter R. Frantz, M.D.	Harvey H. Seegler	Hyndman Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 6 1950
BUREAU V. S.

Within corporate limits
Evidence for addition in #18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

011142

FILM No. G 124 FEB 23 1950 FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (rural) Spring Gap
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Lee (Middle) Alston (Last) Park

4. DATE OF DEATH: (Month) Feb (Day) 9 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: July2-1901

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): material distributor

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel J.Park

14. MOTHER'S MAIDEN NAME: Annie Burch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 705-05-4436

17. INFORMANT: Father, S.J.Park. Spring Gap, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute cardiac failure due to — 3 days

592 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
13/1 (b) uremia

(c) Chronic glomerular nephritis (autopsy) (2/ 23/50 akc)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Feb.9-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Feb. 12, 1950
NAME OF CEMETERY OR CREMATORY: Asbury Chapel Cemetery
LOCATION (City, town, or county) (State): Hardy Co. W. Va.

DATE REC'D BY LOCAL REG.: Feb. 11, 1950
REGISTRAR'S SIGNATURE: Wenter R. Kantz, M.D.
24. FUNERAL DIRECTOR ADDRESS: John J. Hofer, Cumberland, Md.

266-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
FEB 14 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01143

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale Near Cumberland, rural — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale (Near Cumberland, rural)
HOSPITAL OR INSTITUTION OR STREET ADDRESS #8 A. St.,	STREET ADDRESS (If rural, give location) #8 A. St.,

3. NAME OF DECEASED (Type or Print)	(First) GENEVA	(Middle) AMY	(Last) PERRIN	4. DATE OF DEATH	(Month) Feb. (Day) 18, (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 12, 1878	9. AGE last birthday 71 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Bedford Valley, Penna.	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Henry F. Perrin		14. MOTHER'S MAIDEN NAME Amy Robinette			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Miss Lillie Perrin A. St., La Vale			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebro vascular accident	8 months
331 Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	4 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Feb 18, 1950, that I last saw the deceased alive on Feb 18, 1950, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leon M. Simons	M.D.	Cumberland Md	2/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 22, 1950	NAME OF CEMETERY OR CREMATORY Greenmount Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Feb. 21, 1950	REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.	24. FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 1 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01144

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole — LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
HOSPITAL OR INSTITUTION OR STREET ADDRESS 54 Queen Street	STREET ADDRESS (If rural, give location) 54 Queen Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Arthela		Phillips	Feb.	11	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	June 19, 1865	84 yrs.	8	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		West Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Mahala

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Lena Harrison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) myocarditis (failure acute	3 day.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis -	
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
None			m.		

22. I hereby certify that I attended the deceased from ....., 19 46., to Feb 11., 1950., that I last saw the deceased alive on Feb 11., 1950., and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J C Griffin		Keyser W Va	2/11/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-13-50	Queenspoint	Keyser, Mineral Co. W.Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 13/50	[illegible] MD	Rogers Funeral Home	Keyser W Va

RECEIVED
FEB 16 1950
BUREAU V. S.

Within corporate limits

DR. SCHINDLER

3:30 a m

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01145

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (If this place): 38 YEARS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): 117 N. WALNUT PLACE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FRANCES	E.	POUGH	FEB.	15.	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. / Days	If under 24 hrs.: Hours / Min.
FEMALE	COLORED	WIDOWED	JULY 6, 1881	68 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework.	at Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DANIEL BROMERY	FRANCES HARPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hypostatic Pneum. C.V. Renal Disease,	1-2 years
442 Antecedent cause(s)		
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Edema,	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan., 1950, to Feb. 15, 1950, that I last saw the deceased alive on Feb. 14, 1950, and that death occurred at 3 30 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B M. Schindler	M.D.	41 Greene St.	Feb. 15/1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-17-50	Rose Hill Cem.	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 15, 1950	Winter L. Frantz M.D.	Louis Stein Inc. Funeral	Md.

RECEIVED
FEB 21 1950
BUREAU U. S.

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01140

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 6-DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: GARRETT; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: OAKLAND; STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) BABY; (Middle) BOY; (Last) RAILEY

4. DATE OF DEATH: (Month) FEB.; (Day) 9; (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): INFANT

8. DATE OF BIRTH: FEB. 3 1950

9. AGE last birthday: yrs.; If under 1 year: Months; Days: 6; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EARL RAILEY

14. MOTHER'S MAIDEN NAME: VIRGINIA FRIEND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Meningocele	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Meningocele Hydrocephalous	6 days
751 157a	(c)	6 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 3, 1950, to Feb. 9, 1950, that I last saw the deceased alive on Feb. 9, 1950, and that death occurred at 11:40A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W Raye Hodges, M.D. ADDRESS: Cumberland, Md. DATE SIGNED: 2/9/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: 2/11/50; NAME OF CEMETERY OR CREMATORY: Sang Run Cem.; LOCATION (City, town, or county) (State): Garrett Co., Md.

DATE REC'D BY LOCAL REG.: Feb. 11, 1950; REGISTRAR'S SIGNATURE: Wynter K. Hantz, M.D.; 24. FUNERAL DIRECTOR ADDRESS: Herbert C. Leighton - Oakland Md.

2-0-2-03-0-28-2-40-5

RECEIVED
FEB 14 1950
BUREAU V. 9

Within corporate limits

01147

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 8 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 78 Bowery St.

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) P. (Last) Richardson
4. DATE OF DEATH (Month) Feb. (Day) 22 (Year) 1950
5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Aug. 13-1915
9. AGE last birthday 34 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John E. Ross
14. MOTHER'S MAIDEN NAME Laura M. Shimer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-6530
17. INFORMANT Osborne C. Richardson

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

677 Immediate cause (a) Retro-Peritoneal hemorrhage due to a
149a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) rupture of the lower segment of the uterous
(c) following child birth.

INTERVAL BETWEEN ONSET AND DEATH: about 2 Hrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Feb. 22-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2/25/50
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg (State) Md.
DATE REC'D BY LOCAL REG. Feb. 24, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS 23E. Main Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAR 1 1950
BUREAU U. S.

Within corporate limits

01148

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: W. Va. — COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Kirby
STREET ADDRESS (If rural, give location): Near Kirby, W. Va.

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) WALTER (Last) RIDGLEY

4. DATE OF DEATH: (Month) Feb. (Day) 18, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar. 22, 1891

9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ridgley, W. Va.

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: James W. Ridgley

14. MOTHER'S MAIDEN NAME: Louisa Armbruster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 236-14-3352

17. INFORMANT AND ADDRESS: Mrs. Mary L. Ridgley Kirby, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	4 yrs
	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Cumberland (COUNTY) Alleg. (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/14/50, 19....., to 2/18/50, 19....., that I last saw the deceased alive on 2/15/50, 19....., and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE: W. Williams (Degree or title) MD ADDRESS: Cumberland DATE SIGNED: 2/20/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Feb. 21, 1950

NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 21, 1950

REGISTRAR'S SIGNATURE: Winter K. Kantz M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

00000

Mr George -

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

01149

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 517 Linden St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 517 Linden St.

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) M. (Last) Riley

4. DATE OF DEATH: (Month) Feb. (Day) 7 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: June 27-1871

9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Check clerk

10b. KIND OF BUSINESS OR INDUSTRY: Allegany Vocational School

11. BIRTHPLACE (State or foreign country): Gilpentown Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Riley

14. MOTHER'S MAIDEN NAME: Virginia Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-16-2132

17. INFORMANT: Albert S.Schade

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion due to	at once
420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis also had	?
	(c) Arteriosclerosis with hypertention	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M. D.	Cumberland Md.	Feb.8-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 11 '50	St Lukes Cem	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 11, 1950	Winter K. Frank, M.D.	Louis Stein Inc	Cumberland Md

26691

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FEB 14 1950
BUREAU P. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01150

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 309 Cecelia St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 309 Cecelia St.

3. NAME OF DECEASED (Type or Print): (First) Ruth (Middle) Louise (Last) Robinette

4. DATE OF DEATH: (Month) Feb. (Day) 25, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 10, 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George F. Hite

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: R. A. Berry Winchester, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 8 hrs

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/24, 1950, to 2/25, 1950, that I last saw the deceased alive on 2/24, 1950, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE: Drug - M Simmons (Degree or title) M.D. ADDRESS: 128 Union St Cumberland Md. DATE SIGNED: 2/25/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 2-27-1950

NAME OF CEMETERY OR CREMATORY: Davis Memorial

LOCATION (City, town, or county) (State): Near Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 27, 1950

REGISTRAR'S SIGNATURE: Winter R. Kantz, M.D.

24. FUNERAL DIRECTOR: CHARLES L. GEORGE

ADDRESS: Cumberland, Md.

RECEIVED
MAR 6 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01151

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 40 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 930 Glenwood St.	STREET ADDRESS (If rural give location): 930 Glenwood St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Vance	G.	Robinson	Feb.	19	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	married	March.14-1888	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Oiler	Celanese Corp.	Romney W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Luther Robinson	Betty Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	214-07-1398	Mrs. Vance Robinson, 930 Glenwood St., City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Chronic myocarditis	about 5 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

420.1
93d

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland Md.	Feb-20-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-22-50	Greenmount Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 22, 1950	Walter R. Frantz, M.D.	William H. Kight, Cumberland, Md.	

484-16

VS. A15A

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SEP 1 1950
BUREAU V. S.

Within corporate limits

Dr. Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

01152

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 2 hrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) R.D.# 3, Hazen Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alvey	Raymond	Ryan	Feb. 26, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
Male	White	Married	Aug. 11, 1881	68 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor [redacted]	Kelly Springfield Tire Co.	Green Ridge, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel S. Ryan	Sarah J. Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	215-20-6411	Mrs. Myrtha Ryan R.D.3 Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Ulsiene (Thrombosis)	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	years
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 25, 1950, to Feby 26, 1950, that I last saw the deceased alive on Feby 26, 1950, and that death occurred at 3:30A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B. M. Schindler	M.D.	41 Greenway, Cumberland, Md.	Feb. 27, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-28-1950	Zion Memorial	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28, 1950	Walter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

740-69

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MAR 6 1950
FBI - ALBUQUERQUE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01153

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) I. (Last) SEGGIE

4. DATE OF DEATH: (Month) Feb. (Day) 12, (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 12-21-1899

9. AGE last birthday: 50 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: coal mines

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John L. Seggie

14. MOTHER'S MAIDEN NAME: Sarah Foutz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW 2

16. SOCIAL SECURITY NO.: 217-07-2181

17. INFORMANT AND ADDRESS: Mrs. Chas. Seggie, Midlothian, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar Pneumonia — Interval Between Onset and Death: 4 Days

490 X

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

108

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 6, 1950, to Feb 12, 1950, that I last saw the deceased alive on Feb 12, 1950, and that death occurred at 8:25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W O M C Lane M D Frostburg Md 2-13-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-15-50 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 2-15-50 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

454 V2

VS A15

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FEB 20 1950
BUREAU V. S.

DR. R. WILLIAMS

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01154 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND / LENGTH OF STAY (in this place) 4 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 607 MARYLAND AVENUE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE		SELLERS	FEB.	25,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours. Min.
MALE	WHITE	WIDOWED	AUG. 26, 1861	88 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED Machinist	Pittsburgh Clearance Corp	MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Kirtan SELLERS	REBECCA Curry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	4 yrs.
4222 Antecedent cause(s)		
932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
		Cumberland	Alleg	Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 1/10/49, 19..., to 2/25/50, 19..., that I last saw the deceased alive on 2/27/50, 19..., and that death occurred at 12:40 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
O. R. Williams		Cumberland	2/25/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 27, 1950	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 27, 1950	Walter L. Frantz, M.D.	William H. Kight	Cumberland, Md.

326-16

RECEIVED
MAR 6 1950
BUREAU U. S.

Within corporate limits

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01155

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE W. Va. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeley
STREET ADDRESS (If rural, give location) 124 Main St. ✓

3. NAME OF DECEASED (Type or Print): (First) Eleanor (Middle) (Last) Simmons

4. DATE OF DEATH: (Month) Feb (Day) 24 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 3 1915

9. AGE last birthday: 34 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Dawson, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Ross

14. MOTHER'S MAIDEN NAME: Mary Waxler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Homer W. Simmons, Ridgeley, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestinal Obstruction — Interval Between Onset and Death: 2 days

5703 Antecedent cause(s) 1221 — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Strangulated Small Bowel (Ileum), — 2 days

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 22, 1950, to Feb 24, 1950, that I last saw the deceased alive on Feb 24, 1950, and that death occurred at 3:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

B. M. Schindler M.D. 41 Greene St. Cumberland Md. Feb 25, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2/27/50 — NAME OF CEMETERY OR CREMATORY: St Peter & Paul Catholic — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Feb. 27, 1950 — REGISTRAR'S SIGNATURE: Walter K. Kantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 1 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01156

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Franklin — LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS ------

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Franklin---Rural
STREET ADDRESS (If rural, give location) 1 Mi. North of Westernport

3. NAME OF DECEASED (Type or Print): (First) James William (Middle) Harvey (Last) Smiley
4. DATE OF DEATH: (Month) Feb. (Day) 11 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 16, 1888
9. AGE last birthday: 61 yrs. — If under 1 year: Months 11, Days 25 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car-Repairman
10b. KIND OF BUSINESS OR INDUSTRY: B&O R.R.
11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Smiley
14. MOTHER'S MAIDEN NAME: Alice Warnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service) ----
16. SOCIAL SECURITY NO.: 236-03-3911
17. INFORMANT AND ADDRESS: Anna Smiley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis, — year

422.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial Degeneration, — 3mo

934 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterioschlerosis. — 2yrs

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 15, 1949, to 2/II, 1950, that I last saw the deceased alive on 2/II, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE James A. Shantz (Degree or title) — ADDRESS Cudlow W Va — DATE SIGNED 2/14 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE Feb. 14 1950 — NAME OF CEMETERY OR CREMATORY Philos Cem. — LOCATION (City, town, or county) Westernport — (State) Maryland

DATE REC'D BY LOCAL REG. 2.14.50 — REGISTRAR'S SIGNATURE Raymond Mc — 24. FUNERAL DIRECTOR Ellsworth S. Boal — ADDRESS 111 Church St. Westernport, Md.

334-50

RECEIVED
FEB 15 1950
BUREAU V. S.

Within corporate limits DR. DYER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01157

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 419 WINMER STREET

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) M. (Last) SMITH
4. DATE OF DEATH: (Month) FEBRUARY (Day) 4, (Year) 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 6/30/1889
9. AGE last birthday: 60 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: W. Md. RY.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM WALLACE SMITH
14. MOTHER'S MAIDEN NAME: FANNIE ROSE BARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-10-6095
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL-CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 24 hr

443 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardiovascular Disease 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3-, 1950, to 2-4-, 1950, that I last saw the deceased alive on 2-4-, 1950, and that death occurred at 4:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Allen A Dyer, M.D. 247 Va Ave, Cumberland 2-4-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Feb 6-50 | NAME OF CEMETERY OR CREMATORY Greenmount Cem | LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Feb. 4, 1950 | REGISTRAR'S SIGNATURE Verner K. Frantz, M.D. | 24. FUNERAL DIRECTOR Louis Stein | ADDRESS Inc Cumberland Md

20847

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01158

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 408 Magruder St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 408 Magruder St.

3. NAME OF DECEASED (Type or Print): (First) David (Middle) Roy (Last) Snyder
4. DATE OF DEATH: (Month) Feb (Day) 14 (Year) 1950

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH July 5 1874 | 9. AGE last birthday 75 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | 10b. KIND OF BUSINESS OR INDUSTRY Self employed | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel H. Snyder | 14. MOTHER'S MAIDEN NAME Sarah C. Boor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS Mrs Regina Bull Snyder, Cumb'd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x **Immediate cause** (a) Cerebral Vascular Accident — Interval Between Onset and Death: 6 days

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Arteriosclerosis — 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Feb. 14, 1950, that I last saw the deceased alive on Feb. 14, 1950, and that death occurred at 6.45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Arthur F. Jones M.D. | 110 S. Centre St. | Feb. 15, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 2-17-50 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | LOCATION (City, town, or county) Cumberland | (State) Md

DATE REC'D BY LOCAL REG. Feb. 17, 1950 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Louis Stein Inc | ADDRESS Cumberland Md

3147

RECEIVED
FEB 21 1950
BUREAU T. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01159

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 69 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 305 Greene St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 305 Greene St.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Garfield (Last) Sowers

4. DATE OF DEATH: (Month) Feb. (Day) 25 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 10 1880
9. AGE last birthday: 69 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Jacob Sowers
14. MOTHER'S MAIDEN NAME: Mary Keyser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: John J Sowers Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic nephritis

442 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension,

1310 (c) Chronic myocarditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1950, to Feb 25, 1950, that I last saw the deceased alive on Feb 25, 1950, and that death occurred at 8:20 a.m., from the causes and on the date stated above.

SIGNATURE: B. McMacheron, Jr. (Degree or title) — ADDRESS: 49 Greene St Cumberland, Md — DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb 27 50 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Feb. 27, 1950 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

V12-92

RECEIVED
MAR 6 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

01160

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 21hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 306 Harrison St.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) Edward (Last) Speelman
4. DATE OF DEATH: (Month) Feb. (Day) 20 (Year) 19 50

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Aug. 4-1899
9. AGE last birthday: 50 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard clerk
10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry
11. BIRTHPLACE (State or foreign country): Cumberland Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Samuel Speelman
14. MOTHER'S MAIDEN NAME: Harriett Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes ✓ (If yes, give war or dates of service): W.W.1
16. SOCIAL SECURITY NO.: 214-07-2018
17. INFORMANT: Helena Ware

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Subdural hemorrhage due to a	3.1/2 day
903.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under ying cause last 186a (b)	fractured skull	3.1/2 days
(c)		

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Harrison St. — (CITY OR TOWN): Cumberland — (COUNTY): Allegany — (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Feb 17-1950 about 12:30 a.m. — INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Walking on Harrison St fell backward & hit his head on the road.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: H.V.Deming M.D. — (Degree or title): M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Feb.20-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Feb.23,1950 — NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 22, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md

A15A

26647

FEB 24 1950
BUREAU V. S.

Dr. Howard L. Tolson

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01161

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Accident
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) M. (Last) Speicher

4. DATE OF DEATH: (Month) (Day) (Year) February 26 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 8-1-75

9. AGE last birthday: 74 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Speicher

14. MOTHER'S MAIDEN NAME: Catherine Beeghly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

180 Immediate cause (a) Carcinomatosis

Antecedent cause(s)

52a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma - left kidney

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-30-46

19b. MAJOR FINDINGS OF OPERATION: Carcinoma left kidney

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15-, 1950, to 2-26-, 1950, that I last saw the deceased alive on 2-26-, 1950, and that death occurred at 9:31 p.m., from the causes and on the date stated above.

SIGNATURE Howard L. Tolson M.D. (Degree or title) ADDRESS DATE SIGNED 2-27-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: May 1-60 | NAME OF CEMETERY OR CREMATORY: Brethren | LOCATION (City, town, or county) (State): Accident Md

DATE REC'D BY LOCAL REG.: Feb. 28, 1950 | REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Wm Winterberg Grantsville Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 6 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01162

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS In auto, en route to the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 410 Va. Ave.

3. NAME OF DECEASED (Type or Print): (First) Levi (Middle) Kiney (Last) Strawderman, Jr.

4. DATE OF DEATH: (Month) Feb. (Day) 4 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Nov. 15-1896

9. AGE last birthday: 53 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: General hauling

11. BIRTHPLACE (State or foreign country): Mathias W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi Kiney Strawderman, Sr.

14. MOTHER'S MAIDEN NAME: Barbara Mathias

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes W.W. I

16. SOCIAL SECURITY NO.: 220-10-0427

17. INFORMANT: G.S.McDonald, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause (a) Acute cardiac failure due to — Interval Between Onset and Death: about 5 minutes

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis also had — about 2 years

(c) hypertention — ? !

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Feb.4-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 7, 1950 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb 4, 1950 — REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D. — 24. FUNERAL DIRECTOR: James Scarpelli — ADDRESS: Cumberland, Md.

42050

VS. A15A

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

01163

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 307 Baltimore Ave.	STREET ADDRESS (If rural, give location) 307 Baltimore Ave.

3. NAME OF DECEASED (Type or Print)	(First) BERTIE	(Middle) PAULINE	(Last) TAYLOR	4. DATE OF DEATH (Month) (Day) (Year) Feb.12,1950 19
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 19,1900	9. AGE last birthday 49 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles S. Ring		14. MOTHER'S MAIDEN NAME Hannah Rice		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Lindley Taylor, Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Sudden
260 Antecedent cause(s)		
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension & Cardio Vascular Disease	3 yrs.
	(c) Diabetes Mellitus	10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to Feb. 12, 1950, that I last saw the deceased alive on Feb. 12, 1950, and that death occurred at 7 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. J. Jurrett	M.D.	Cumberland	2/13/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb.15,1950	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Feb. 15, 1950	REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

RECEIVED
FEB 21 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01164

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 128 Wood St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 128 Wood St.

3. NAME OF DECEASED (Type or Print) (First) Ralph (Middle) Thomas (Last) Tharp, Jr.

4. DATE OF DEATH (Month) 2 (Day) 10 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Feb-14-48
9. AGE last birthday 1 yrs. If under 1 year: Months 11, Days 26; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Miner's Hospital, Md.
12. CITIZEN OF WHAT COUNTRY? N.S.A.

13. FATHER'S NAME Ralph Thos. Tharp
14. MOTHER'S MAIDEN NAME Mary Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mr Ralph T. Tharp, 128 Wood St Frostburg Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.5 Immediate cause (a) Sudden Cardiac Failure, due to — Instantan-

Antecedent cause(s)

157f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coarctation of Aorta + Hypertension — 1 yr.

(c) Chr. Bronchitis — ± 3 mos.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-4, 1949, to 2-10, 1950, that I last saw the deceased alive on 2-8, 1950, and that death occurred at 1:35P m., from the causes and on the date stated above.

SIGNATURE Frank T. Harrat (Degree or title) Md. ADDRESS 59 E. Main St. Frostburg Md. DATE SIGNED 2/11/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-13-50
NAME OF CEMETERY OR CREMATORY Allegany
LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 2-13-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md

XVX

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 20 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01165

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 635 Sedgewick St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 635 Sedgewick St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Lehmon (Last) Topper.

4. DATE OF DEATH: (Month) Feb (Day) 25 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov 23 1865

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Charles A Weibel Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerbral Hemorrhage — Interval between Onset and Death: 10 hours

331 / X Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 25, 1950, to Feb 25, 1950, that I last saw the deceased alive on Feb 25, 1950, and that death occurred at 1 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

R. W. Trovarkis, M.D. Cumberland, Md 2/27/50

23. BURIAL, CREMATION, REMOVAL (Specify): Final — DATE: Feb 28 50 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Feb. 28, 1950 — REGISTRAR'S SIGNATURE: Walter L. Wantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Louis Stein Inc Cumberland

RECEIVED
MAR 6 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01166

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY - Allegany; STATE - MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN - Cumberland; LENGTH OF STAY (in this place) - 7.1/2 hrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS - 6 Altamont Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE - Md.; COUNTY - Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN - Frostburg; STREET ADDRESS (If rural give location) - 92 Mt. Pleasant St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Russell	Geary	Uhl	Feb.	2	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	married	May 3. 1913	36 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Used car dealer	Sales Tri-State Motor	Mt. Savage Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mervin Uhl	Catherine Geary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes W.W.2	217-05-8040	Mervin Uhl (brother) Mt. Savage Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary occlusion	7.1/2Hrs.
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a (b) Arteriosclerosis	?
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H. V. Deming M.D.	Cumberland Md.	Feb. 2-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 5' 50	Methodist Cem	Mt Savage, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4, 1950	Walter K. Frantz, M.D.	Louis Stein Inc	Cumberland Md

15669

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 7 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01167 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 5 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Star Route, Flintstone
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): East Side Polish Mountain

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Frank	(Last) Wallizer	4. DATE OF DEATH	(Month) 2 (Day) 14 (Year) 1950
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 10/18/1857	9. AGE last birthday: 92 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming (Retired)	10b. KIND OF BUSINESS OR INDUSTRY: Own Farm	11. BIRTHPLACE (State or foreign country): Lock Haven, Penna	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: John K. Wallizer	14. MOTHER'S MAIDEN NAME: Mary Eliz. ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Wade Wallizer, Flintstone, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442X Immediate cause (a) Carded - vascular renal disease — 2 years

Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-9, 1950, to 2-14, 1950, that I last saw the deceased alive on 2-14, 1950, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. E. Johnson Jr.	M. D.	Cumberland Md	2-17-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Feb 17, 1950	NAME OF CEMETERY OR CREMATORY: Robinette Family Cem.	LOCATION (City, town, or county) (State): Near Flintstone, Md.
DATE REC'D BY LOCAL REG.: Feb. 17, 1950	REGISTRAR'S SIGNATURE: Wrntes R. Frantz M.D.	24. FUNERAL DIRECTOR: John J. Hofer, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 21 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01168

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Rural
STREET ADDRESS (If rural, give location) Rt.1 Braddock Farm

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Mary	Alice	Walter		2	7	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
F	W	W	April 13, 1876	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Buck Valley, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Norris
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Daughter-Mrs. Lula Hughes, Rt.1 Braddock Farm

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	3 hrs
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	1 yr.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 24 19[illegible], to Feb. 7, 1950, that I last saw the deceased alive on Feb. 4, 1950, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Arthur F. Jones M.D. 110 S. Centre St. Feb. 7, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-10-1950	Garrett Cem.	Garrett, Penna.

DATE REC'D BY LOCAL REG. Feb. 8, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, MD
24. FUNERAL DIRECTOR ADDRESS: Charles L. George Cumberland, Md.

RECEIVED
FEB 14 1950
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01169

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Jessie (Middle) May (Last) Washburn
4. DATE OF DEATH: (Month) 2 (Day) 9 (Year) 1950
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: May 11, 1881
9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Allegany Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Solomon Cook
14. MOTHER'S MAIDEN NAME: Martha Robbins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Bro-Chas. Cook Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Adenocarcinoma Uteri — 8 mo

174 Antecedent cause(s)

48 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1949, to Feb. 9, 1950, that I last saw the deceased alive on Feb. 7, 1950, and that death occurred at 3:18 a.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones M.D. (Degree or title) — ADDRESS: 110 S. Centre St. — DATE SIGNED: Feb. 10, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb. 11, 1950 — NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 11, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

RECEIVED
FEB 14 1950
BUREAU V. S.

DR. DYER

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01170

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND? MD.
LENGTH OF STAY (in this place): 21 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 139 ELDER STREET

3. NAME OF DECEASED (Type or Print): (First) MARIE (Middle) (Last) WILKINS

4. DATE OF DEATH: (Month) 2-6-50 (Day) (Year) 19

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: 4-26-1872

9. AGE last birthday: 77 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ferdinand PETERS

14. MOTHER'S MAIDEN NAME: CATHERINE Wack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND? MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac decompensation — Interval between onset and death: 4 years

434.3 Antecedent cause(s)

95c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to 2-6, 1950, that I last saw the deceased alive on 2-6-, 1950, and that death occurred at 2:08p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A Dyer, M.D. 247 Va ave, 2-7-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-9-1950 — NAME OF CEMETERY OR CREMATORY: Philos Cem. — LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: Feb. 8, 1950 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Charles L. George Cumberland, Md.

RECEIVED
FEB 14 1950
BUREAU OF S

Within corporate limits L. Jennings MS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01171

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH-COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED-STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 67 Greene St	STREET ADDRESS (If rural, give location): 67 Greene St.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Beaumont (Last) Williams				4. DATE OF DEATH (Month) Feb. (Day) 1, (Year) 1950			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Feb. 2, 1884	9. AGE last birthday: 65 yrs.	If under 1 year: Months.	Days	If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired	10b. KIND OF BUSINESS OR INDUSTRY: Salesman	11. BIRTHPLACE (State or foreign country): Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME: Henry B. Willams		14. MOTHER'S MAIDEN NAME: Jacobeni Connor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Mrs. Melissa Williams					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hepatic coma	1 day
581.0 Antecedent cause(s)		
124.b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Liver cirrhosis	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-10-, 1949, to 2-1, 1950, that I last saw the deceased alive on 1-31-, 1950, and that death occurred at 8:45 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. K. Krantz	MD	57 Greene St.	2-2-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-3-1950	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 3, 1950	Winter K. Krantz, M.D.	Charles L. George	Cumberland, Md.

27999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 7 1950
BUREAU V. S.

Within corporate limits

Dr. F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01172

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 39 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 654 WASHINGTON STREET

3. NAME OF DECEASED (Type or Print): (First) DR. FRANK (Middle) M. (Last) WILSON

4. DATE OF DEATH: (Month) FEB. (Day) 23 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: NOV. 7, 1890

9. AGE last birthday: 59 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SURGEON

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. JONES WILSON

14. MOTHER'S MAIDEN NAME: Marie JOSEPHINE MC CORMICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If year, give war or dates of service) 1st WW

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchogenic Carcinoma (Rt.) — Interval Between Onset and Death: Oct 49.

162 Antecedent cause(s)

47c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Nov 49

19b. MAJOR FINDINGS OF OPERATION: See above

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-24, 19 49, to 2-23, 19 50, that I last saw the deceased alive on 2/23, 19 50, and that death occurred at 12:25 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. F. Williams Cumberland 2/24/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-26-50 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county): Cumberland — (State): Md.

DATE REC'D BY LOCAL REG.: Feb. 25, 1950 — REGISTRAR'S SIGNATURE: Walter R. Lantz M.D. — 24. FUNERAL DIRECTOR: Lons Stein Inc — ADDRESS: Cumberland Md

V32-92

RECEIVED
MAR 1 1950
BUREAU V. S.

Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01173

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 13 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CORRIGANSVILLE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) ROBERT (Middle) (Last) WINGERT

4. DATE OF DEATH (Month) (Day) (Year) FEB. 25 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH JUNE 11, 1901

9. AGE last birthday 48 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Miner

10b. KIND OF BUSINESS OR INDUSTRY Coal Mines

11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WALTER L. WINGERT

14. MOTHER'S MAIDEN NAME SHAFFER ELEANOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. 214-01-6729

17. INFORMANT AND ADDRESS Mrs. Lilabel Wingert, Corrigansville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Peritonitis

572.1, Antecedent cause(s) (b) Ruptured diverticulitis

123 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) of sigmoid

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Feb 4 50

19b. MAJOR FINDINGS OF OPERATION Peritoneal cavity filled with pus

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 4, 1950, to Feb 25, 1950, that I last saw the deceased alive on Feb 25 1950, and that death occurred at 9:47 P.m., from the causes and on the date stated above.

SIGNATURE S. E. Enfield (Degree or title) ADDRESS Cumberland DATE SIGNED 2/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Feb. 28, 1950

NAME OF CEMETERY OR CREMATORY Lutheran Cemetery

LOCATION (City, town, or county) Wellersburg Pa (State)

DATE REC'D BY LOCAL REG. Feb. 28, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Harvey H. Tugler, Hyndman, Pa. ADDRESS

454-12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

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MAR 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01174

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (In this place) 5 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	A	Winner	Feb	17	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	June 24, 1879	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Work		Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Anton Winner	Mary Entler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		Mrs William Winner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Primary Carcinoma right lung.	6 Mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	
	(c) Arterio - Sclerosis.	

162
47d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-16, 1950, to 2-17, 1950, that I last saw the deceased alive on 2-17, 1950, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. C. Dickel M.D.		Frostburg, Md.	2-18-50.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 20, 1950	St Ann's Cemetery	Avilton, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-20-50	Mrs Nancy A. Roe	M. Eichhorn	Lonaconing, Md.

9814

RECEIVED
OCT 24 1950
BUREAU V. S.

Within corporate limits

Evidence for change of age shown on:

FILM No. G 124 FEB 20 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01175

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 60 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 304 Park Street	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 304 Park Street
3. NAME OF DECEASED (Type or Print): (First) J. (Middle) WILLIAM (Last) WOLFE	4. DATE OF DEATH (Month) (Day) (Year): Feb. 9, 1950
5. SEX: Male; 6. COLOR OR RACE: White; 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Nov. 28, 1878; 9. AGE last birthday: 71 ~~72~~ yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Piano Tuner; 10b. KIND OF BUSINESS OR INDUSTRY: Self	11. BIRTHPLACE (State or foreign country): Maryland; 12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: John Wolfe	14. MOTHER'S MAIDEN NAME: Melissa White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None
	17. INFORMANT AND ADDRESS: Edward Wolfe, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	2 da.
420.1 Antecedent cause(s)	(b) Coronary Heart disease	
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Generalized arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized Rheumatoid arthritis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 11, 1950, to Feb. 9, 1950, that I last saw the deceased alive on Feb. 9, 1950, and that death occurred at 3.40 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James P. Wiseman	MD	310 Decatur St. Cumberland Md.	2/9/1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 11, 1950	Hill Crest Burial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 11, 1950	Hunter R. Frantz, M.D.	William H. Kight	Cumberland, Md.

39085

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FEB 14 1950
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